IN THE MATTER OF THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HALLETT

MODULE 2 CLOSING STATEMENT FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

Table of contents

1. These written submissions are made as an enlarged and more discursive version of our oral closing statement of December 14, 2023. They incorporate our reflective observations after reviewing the voluminous material disclosed by the Inquiry along with the oral evidence heard during the course of this module.

2. For ease of reference, our submissions seek to examine government decision-making under 5 headings:
    i. knowledge of risk;
    ii. failures of pandemic pre-planning;
    iii. absence of leadership;
    iv. failings in the contemporaneous strategic response; and
    v. the human rights framework.

Introduction

3. Within the NHS, a global beacon of healthcare excellence, of the more than 1 million workers employed a huge proportion hail from ethnic minority backgrounds. This is a testament to the rich diversity that makes our healthcare system resilient and renowned. Yet, these same individuals faced disproportionate risks and burdens during the pandemic, exposing a deep-seated issue that demands public attention and urgent remediation.

4. Ade Adeyemi, on behalf of FEMHO in the first week of hearings, underscored a critical observation:

“The *system can pick up signals and noise and disruption in other areas, but when there's noise and disruption of Black and Asian Ethnic Minority workers, it's not heard and it's not responded to immediately...when we did say these things, and when systemically it's happening across the NHS system, across the country, it's not being immediately believed, it's not being immediately responded to, it creates that understanding or perception that there is an institutional systemic response for one set of problems, and for our members, Black and Asian Ethnic Minority workers, there is a different systemic response…that’s not proportionate to the scale of the problem.*"

[4/106/16 - 4/107/7]

5. Throughout Module 2, FEMHO’s over-arching contention has been that the pandemic transcended mere health implications; it was a political, social and economic emergency. This crisis, compounded by the government's seemingly callous prioritisation of the economy over public health, intensified into a health and human rights catastrophe. The evidence presented during Module 2's investigation has laid bare the profound and disproportionately adverse consequences of policy decisions - or lack thereof - on the lives of Black, Asian, and Minority Ethnic health and social care workers and their communities. These decisions, magnifying pre-existing inequalities, underscore the urgent need for a thorough re-evaluation of the government's approach to such crises.

6. Societal factors, in particular socio-economic factors, that were well known and understood prior to the pandemic within the public health sector and government combined to produce adverse discriminatory outcomes. This is a reflection of structural inequality. Properly put, in the context of Black, Asian and Minority Ethnic people, it is structural racism.

7. Professors Nazroo and Becares, the Inquiry’s race inequality experts, contextualised structural racism in their joint report as follows:

“*Historical and ongoing* ***structural racism*** *means that ethnicity remains strongly associated with social location, status and power, leading to inequalities in access to key economic, physical, political, social and cultural resources. (Phillips, 2010; Bailey et al., 2017). This results in deep and persistent socio-economic inequalities, justified through the use of negative, often denigrating, stereotypes attached to members of ethnic minority groups (Emirbayer and Desmond, 2015). The social and economic inequalities consequent on structural racism make a substantial contribution to the ethnic inequalities in health that we have described in Topic 2 (Nazroo, 2001a; Chouhan and Nazroo, 2020)”*

[INQ000280057/15, Para 42]

8. We note that Health Secretary Matt Hancock was keen to emphasise his awareness of what he called the "*long-standing issue of racism within the NHS*" and that he had been heavily involved in and concerned about "*well before the pandemic*". [30/84/24 – 30/85/5]

9. In the lived experience, structural racism translated into a higher risk of infection, severe illness, and death for people from ethnic minority backgrounds during the pandemic. This compounded the pre-existing structural inequalities the Black, Asian and Minority Ethnic health and social care staff experience. We encountered disadvantages across a spectrum of impacts created by the virus including, at its most fundamental level, increased exposure and restricted access to resources for prevention, treatment, and care for Covid-19. For members of FEMHO, many of whom courageously served on the frontline and were already facing exponentially increased risks due to the nature of their work, the pervasiveness of structural racism left us severely exposed and without the essential support we desperately needed.

10. The alarming, yet sadly predictable, signs of this disproportionate impact emerged and were felt at the earliest stages of the pandemic's arrival to the UK. An article run by The Independent voices on 19 March 2020 was headlined "*NHS officials told me Muslim households are particularly vulnerable to coronavirus – it's important to understand why*". The Guardian on 29 March 2020, in an article headlined *"NHS consultant dies from Covid-19",* reported the first confirmed death of a frontline hospital worker in the UK as Amged el-Hawrani, an NHS consultant. The article also noted the death of Adil el Tayar the previous week, a surgeon who had been volunteering in A&E departments against the outbreak. Just a few days later, on 1 April 2020, The Guardian reported on the death of Dr Alfa Saadu, a retired medical director who had been volunteering at a hospital in Welwyn, and that of General Practitioner Dr Habib Zaidi, in an article headlined *"Retired hospital medical director latest to die from Covid-19 in UK."*. On the same day Professor Khunti, who later became Chair of the SAGE Ethnicity sub-group, raised alarm via a tweet [INQ000223026] having heard that hospitals and ICUs were seeing a high proportion of severe Covid admissions from ethnic minority groups, in particular young South Asian people. On 3 April 2020, The Guardian ran an article headlined *"UK doctors' coronavirus deaths highlight crucial role of BAME medics",* recognising that the first four deaths of healthcare workers in the UK were from minority ethnic backgrounds.

11. News continued to spread and gain coverage in early April, with the BBC running an article on the 4th headlined "*Coronavirus: Coming 5,000 miles to die for the NHS*" which focused on the deaths of two British-Sudanese doctors. The Guardian ran an article on the 7th, headlined *"BAME groups hit harder by Covid-19 than white people, UK study suggests,"* reporting on the release of data from the Intensive Care National Audit and Research Centre's initial research which found that in the crucible of intensive care units, where life hung in the balance, 35% patients were non-white, nearly triple the 13% proportion in the UK population as a whole, and that 14% of the most serious cases were Asian and 14% Black. The Guardian newspaper on 10 April 2020 reported that the first ten doctors to die from Covid-19 in the UK were from ethnic minority backgrounds, in an article headlined *"UK government urged to investigate coronavirus deaths of BAME doctors."*.

12. Shocking evidence then emerged from the British Medical Association in an article headlined *"COVID-19: the risk to BAME doctors",* that up to April 2020, 95% of doctors and 64% of nurses who had died were from Black, Asian and Minority Ethnic communities, despite making up just 44% and 20% respectively of those staff groups. ONS data on Covid-19 related deaths by ethnic group, released in May 2020 revealed that Black males were found to be 4.2 times more likely to succumb to a Covid-19-related death than their white counterparts, while Black females faced a 4.3 times higher risk. A study carried out by UK-REACH, titled *"United Kingdom Research study into Ethnicity And Covid-19 outcomes in Healthcare workers (UK-REACH): a retrospective cohort study using linked routinely collected date, study protocol,"* published in June 2021, spanning the first year of the pandemic in the UK later reported that during this period ethnic minority healthcare workers accounted for 65-76% of deaths despite contributing less than 20% of the NHS workforce.

13. These devastating facts are not merely statistics; they represent what our members witnessed firsthand around them in the health system and the tragic loss of colleagues and friends, skilled individuals who put their lives on the line for the care and protection of others. The stark disparity underscores the urgent need at the time for a comprehensive examination of the systemic factors contributing to these alarming outcomes, demanding immediate attention and remedial action, which was sadly lacking.

14. FEMHO steadfastly advocates for the rights of ethnic minority health and social care workers, and on the broader principle that the government's actions – or inaction – have far-reaching consequences and affect every individual within its wider communities. The decisions made within the corridors of power in central government, and/or the failures to

make appropriately strategic decisions to mitigate and protect, during the Covid-19 crisis have not only driven but exacerbated longstanding inequalities within Black, Asian and Minority Ethnic health and social care workforces and communities.

15. The government's emergency planning and pandemic resilience efforts should have anticipated that known health and socioeconomic inequalities, compounded by structural racism and broader issues such as austerity, would intensify vulnerability. Without active steps to mitigate and protect, this would inevitably lead to disproportionately adverse health outcomes and impacts for Black, Asian and Minority Ethnic health and social care workers and communities.

16. This perspective aligns with the documented reality that certain ethnic and racial groups suffer higher rates of respiratory diseases. Moreover, the substantial representation of Black, Asian and Minority Ethnic people at higher risk of exposure due to increased likelihood of working in public-facing roles, underscores the necessity for government decision-making to have prioritised considerations of race and ethnicity during a pandemic.

17. It is a glaring indictment of governmental policies and decision-making that, despite the known embedded structural inequalities faced by Black, Asian and Minority Ethnic health care workforces, the Inquiry heard evidence that there was a failure for a considerable period of time to even acknowledge ethnicity as a risk factor within the NHS. Further, Black, Asian and Minority Ethnic staff experienced unequal access to PPE. FEMHO's Ade Adeyemi's evidence revealed that 64% of Black, Asian and Minority Ethnic doctors felt pressured to work in settings with inadequate PPE, compared to 33% of their white counterparts [INQ000280065/13]. Fit-testing of PPE was inconsistently carried out, and was often said to be ineffective and for some discriminatory. We have heard shocking anecdotal stories for example of individuals with religious headwear and/or beards being forced to remove and shave them in order to pass a fit test, with no offering of alternative and compatible PPE, exposing a dangerous and egregious failure in the government's duty to protect its frontline workers.

18. Witness after witness lamented the absence of a proper functioning system of data collection. There was almost a complete "black-out" in data capture for Black, Asian and Minority Ethnic communities during the early stages of the pandemic, because of the absence of any disaggregation based on race or ethnicity. Computational modelling did not include ethnicity, because there was simply no capacity to do this work both because

of the absence of data; and due to the fact that models were not built to include ethnicity considerations.

19. The disregard for essential information continues, with ethnicity still not being recorded on death certificates. We heard from the Inquiry's race inequality expert Professor Nazroo on how this resulted in undercounting of deaths [3/43/1 – 3/44/1] and how workarounds to attempt to link datasets together had to be created to estimate disaggregated data. This grave omission obscured the true impact of health inequalities on ethnic minority communities, hindering effective policy responses.

20. On the issue of messaging and communication, FEMHO is of the view that there was not just a flaw in government decision-making, there was a deadly barrier that perpetuated the disparities faced by ethnic minority communities. Chief Medical Officer ("CMO") Professor Chris Whitty acknowledged in his evidence that guidance only reached some ethnic minority people through the efforts of groups like FEMHO [24/116/17 – 24/117/15]. Rather than being "hard to reach", ethnic minority communities were failed by the formal systems; and instead, had to rely on their community leaders to pick up the slack, including dissemination of essential information in community languages.

21. Under unimaginable levels of stress from the relentless work to protect against and treat patients with Covid and simultaneously keep the country's healthcare system running as close to near normal as possible, all these factors and more combined to create a significant additional physical and mental burden for our members. Many feared speaking out or refusing to work in unsafe conditions due to negative professional and/or visa consequences whilst many of those who were brave enough to speak out felt their voices were ignored. We were let down by decision-makers who left us unprotected and vulnerable to higher risks of exposure and infection, and with a plethora of additional and disparate burdens to manage.

Submissions

22. In light of the evidence that has been heard and disclosed in this module, FEMHO makes the following submissions:

I. Knowledge of risk

23. FEMHO's submission is that senior decision makers *knew* or *ought to have known* that in a pandemic, there would be variability in impact and outcome based on ethnicity. It was well-known that structural health inequality would have driven vulnerability within Black, Asian and Minority Ethnic health and social care worker communities. This was not an assertion of left-wing politics but a well-appreciated understanding within the purview of public health.

24. The Inquiry's race inequality expert, Professor Nazroo, confirmed that ethnic inequalities in health had been "*documented for several decades*" prior to the pandemic and are a "*longstanding and persistent*" issue in the UK. [INQ000280057/7] Experts in infectious disease similarly spoke to and reinforced the foreseeability of disparate impacts; Professor Ferguson for example stated: "*it didn't come as any surprise to me. I mean, pandemics build on the pre-existing health inequity, and there is already health inequity between ethnic – inequity between different ethnic groups in the United Kingdom.*" [11/212/3-6] –]

25. The most explicit acknowledgment and confirmation that the that variability of health outcomes based on ethnicity was foreseeable, came in the evidence and testimony of the Government Chief Scientific Adviser (GCSA), Sir Patrick Vallance. He informed the Inquiry that this phenomenon was deeply rooted in health inequality and would have formed part of the advice that was given to policy makers in the lead-up to and early stages of the pandemic. In answering questions from FEMHO's junior counsel, this exchange ensued:

    PD: *It's at INQ000238826_180, it's the first paragraph of the section of your witness statement entitled "Covid-19 Disparities", and you say this: "I was aware that the pandemic, and the measures required to tackle it, [could] have an unequal impact. As I stated at more than one press conference, the virus fed off inequality and drove inequality ... **It was entirely foreseeable that pre-existing structural and health inequalities within ethnic minority and other vulnerable groups would result in disparities in risk and outcome."** Can I ask, firstly, whether this clear understanding expressed here formed* *part of the advice to senior decision-makers as you and Sir Chris Whitty spoke with them in the period leading up to the first lockdown in March 2020?*

SPV: *I think it was -- I mean, it's historically -- this is* ***an historically true statement, that pandemics differentially affect the most disadvantaged people and they drive further disadvantage and inequality,*** *and this is a statement that describes that. <u>I can't recall exactly when we would have given that advice</u>, and in a sense <u>it's not really science advice</u>, but it is <u>something that policymakers needed to take into account</u> and, I'm sorry, I don't know exactly when we would have first raised this<u>. I raised it at a press conference pretty early on, I know that.</u>*

PD*: Very well, but you wouldn't be able to say whether this was advice that, as a general proposition, could be infused or was infused in the type of advice that you would have given?*

SPV: *I'm <u>pretty sure that Chris Whitty would have said this very early on,</u> but I'm sorry, I don't have any -- exact date as to when that would have been said.*

[22/174/18 – 22/175/10, emphasis added]

26. Sir Patrick Vallance was at pains to clarify that these were not political issues but *bona fide* matters of public health:

PD: *Would you say, in reflection, that there was any nervousness to speak authoritatively on issues of disparity in health outcomes based on ethnicity?*

SPV: *No, I think we -- well, certainly not from our perspective. We <u>very early on raised this as an issue,</u> we were very <u>keen to see it properly understood</u>, Public Health England undertook work and published it, and the ONS also undertook work and published it, so we were keen to actually try and understand what was driving it. And I think quite <u>early on -- I don't remember the date, I'm sorry -- we came to the conclusion that the likely causes was to do with inequality and to do with issues of health related inequality,</u> rather than to biological differences which were driving this outcome at that stage.*

PD: *Very well. My final question: is it fair to say that during this time, on or around the middle of April 2020, the matter of disproportionate deaths based on ethnicity was considered more a matter of public messaging, political messaging, rather than a bona fide issue of public health?*

SPV: *No, I think it was seen by the public health people very much as an issue of public health, and that there were obviously pre-existing structural inequalities that were causing* *a problem and, as I've already said in a previous quote, I was worried that not only was there inequality in terms of what the effect of the virus was, but the virus itself was then driving even further inequality because of that. So I think this was seen as absolutely a public health issue.*

[22/177/16 – 22/178/22]

27. The CMO, Sir Chris Whitty, offered a slightly more nuanced view of these issues. His responses to FEMHO's senior counsel suggest that ethnicity, without more, was not recognised as readily presenting all the risks and variability of health outcomes from Covid. However he too agreed that disproportionate impacts on ethnic minority groups were, at least in some ways, predictable. He suggested that these are considerations that could have been basis for pause in interpreting early data about Covid-19 casualties:

LTKC: *Can we agree that it was at least possible to attempt to predict that certain groups would be at higher risk, including health and social care workers, you know, from minority or minoritised groups, fairly early on in this pandemic? Can we agree that?*

SCW: *I think it was possible to agree – well, I think it was possible to predict and I have gone into this in some detail in my statement, so can I point your members to my statement so they can see a full answer to this.* ***It was certainly possible to identify the fact there would be areas of – there would be people, disadvantaged groups, who would be particularly affected.*** *My view then and subsequently is that <u>not all of them were fully predictable, including some of the impacts of ethnic minority – ethnicity absent the socioeconomic deprivation points</u> that you've previously made. I think that was a* ***more complicated area and that took longer for us to unravel and properly to understand, and therefore, more importantly, to work out what we could do to address.***

LTKC: … *what protective steps and measures were taken to protect those groups based on those protections?*

SCW: *Remembering that this is a highly contagious infection, the <u>single most important thing to protect every group was to get Covid down in the entire community.</u> Without doing that everything else falls by the wayside. So that was the single priority at the beginning. As things went on, I was very, very keen to identify these points, and again laid out in my statement the multiple steps we took to try to understand this. And, you know<u>, I accept the point you're making, but I think at the beginning the absolute priority was to pull down</u>*

<u>Covid rates in everybody, across the whole community. That is the best way to protect everybody.</u>

[24/128/2 – 24/129/14, emphasis added]

28. Sir Chris Whitty's comments at the hearing appear to be consistent with his contemporaneous utterances. Nevertheless, they still concede the link between ethnicity and heightened risk during the pandemic. In a draft report from Sir Chris Whitty titled *Interim information note on PHE's work on ethnicity and COVID-19*, dated 12/05/2020:

P1.-2 "Some clear messages come from this report, but with some caveats. Routine data on ethnicity is often incomplete. The data available did not allow for full testing of the impact of differences in co-morbidities as an explanation for the differences. And it is clear from the data that different ethnic minority groups differ in a number of respects that might affect their risk of a poor outcome from Covid-19

[..]

6) People from some ethnic minority backgrounds (notably of Black Caribbean heritage) are more likely to be tested for COVID-19 than the White British population. This needs to be interpreted remembering that during the period these data were collected almost all tested were hospitalised, so in reality this means were more likely to have significantly symptomatic COVID-19.

7) The positivity rate for COVID-19 was higher in those tested in most ethnic minority groups, so this was not because they were being tested with a lower threshold. People of Black ethnic groups had the highest proportion of positive tests at 44.5%, followed by people in Asian ethnic groups with 39.4%, where the test positivity rate in the White population was 29%. 8) Overall, there were 196/100,000 population who tested positive for COVID-19. Black ethnic groups were higher at 269.0/100,000 and rates were particularly high for Black Caribbean ethnicity 333.4/100,000.

[…]

9) Overall this implies the rate of acquiring COVID-19 is higher in several ethnic minority groups. [DN: Could this also be the result of different patterns of healthcare access and utilisation, with late diagnosis and more complication presentation being a feature in some communities?] We need community studies before this can be tested with certainty, but it is probable.

10) Higher risks for becoming infected could include greater urban living, socioeconomic factors, being in person-facing jobs; genetic factors cannot be excluded. The ONS data published yesterday shows a clear association between one's occupation and the probability of social contact and risk of exposure to COVID with the highest risk of COVID-19 deaths seen among low-skilled workers such as male security guards, taxi drivers and chauffeurs - professions with high proportion of BAME workers."

[INQ000069211/1-2]

29. The evidence of Mr Dominic Raab, who deputised as Prime Minister in April 2020, asserted that there was a state of "*uncertainty*" about the reason for disproportionate deaths among Black, Asian and Minority Ethnic health and social care workers. His argument essentially was that because of this supposed lack of clarity, there was paralysis of government in their ability to make any useful reaction in terms of policy. He responded to FEMHO's junior counsel as follows:

PD: *Firstly, in the absence of the Prime Minister between 5 and 25 April during his hospitalisation, were you specifically called on to address the matter of disproportionate death rates within black, Asian and minority ethnic community…by your advisers or anyone?*

DR: *No, not specifically in that way. I was, as I'm sure everyone in Cabinet and in government was mindful of some of this data and evidence coming through. The reality was when -- and we had quite a few conversations with the chief scientific officers and Chris Whitty and others, and I think even by that point it just – the <u>data and the evidence was too fluid for us to be able to come to any definitive conclusions,</u> let alone actionable policy making, and therefore we were mindful that there was some clearly more examination of this that was required, and I remember asking -- being involved in those discussions. But we just didn't have enough firm enough conclusions, and the science wasn't firm enough to be able to take it forward.*

[…]

PD*: What was your understanding of this particular phenomenon? What, for example, was your view of what was driving these outcomes?*

DR*: It wasn't clear. I think the one thing I was mindful of is the importance of being able to disaggregate data in a way which doesn't lead you up a – down a – it doesn't give you a false lead. And ... but to be honest with you, what I thought my role – and I often do this,* *particularly outside the area of being Foreign Secretary at that time, which is obviously my portfolio – is to try and test and challenge. I think we did do quite a lot of that on this. <u>So it wasn't the absence of asking the question, I just don't think that the evidence had firmed up with the kind of – to use the Inquiry's terminology – consensus view of SAGE or otherwise.</u> So, sure,* ***there were evidential leads that were emerging, all of which required proper examination, but did that lead to clear consensus? Well, not to my knowledge from the CMO or SAGE.***

[28/240/13 – 28/242/11, emphasis added]

30. He further asserted that without firm evidence there was no scope for contemporaneous strategic responses:

PD*: Can I ask: what, if any, contemporaneous strategic response was pursued regarding this issue?*

DR*: With respect, sir, I think I've answered that, which is that <u>I think it was very difficult to come up with a strategic response in the absence of firm evidence,</u> and the <u>risk would have been you would have got your strategy wrong,</u> if your evidence base wasn't firm enough.*

PD: *So I take it that that is a wait and see?*

DR: *We're always desperate to get more evidence and then respond to it as it firmed up, and as we had a clearer idea of what the implications were, and indeed the implications of the various policy options.*

[28/243/16 - 28/244/3, emphasis added]

31. Remarkably, Mr Raab rejected Sir Patrick's view that variability of health outcomes based on ethnicity was foreseeable and suggested that Sir Patrick could only now have come to this view, with the benefit of hindsight and more data for considered reflection:

PD*: This Inquiry has heard a fair amount of expert evidence, including from Sir Patrick Vallance, that disparities in health outcomes from the pandemic were "<u>entirely foreseeable".</u> This would tend to support your observations about the impact of lockdown on poorer children and those from ethnic minority backgrounds. How, then, do you reconcile this understanding with what you say earlier in the same paragraph, that is* *paragraph 212, <u>where you say that you did not have much learning on the variable impact of Covid on those from ethnic minority backgrounds?</u>*

DR: *<u>At the time we didn't. So, Patrick may say we do now, of course that's the point of this Inquiry,</u> and I think learning lessons and as the evidence evolves, because of course a huge evidence base is coming out of the pandemic, <u>but at the material time at which these decisions were making,</u> I think that's correct.*

[28/245/18 – 28/246/9, emphasis added]

32. Contrary to Mr Raab's position, there is substantiating evidence supporting Sir Patrick's perspective that it was part of public health orthodoxy that there would be variability in health outcomes during the pandemic, based on vulnerability. *DHSC Guidance dated 22/02/20* at p.18 - para 58 - final bullet, for example prognosticated that: "*there could well be an increase in deaths arising from the outbreak, particularly amongst vulnerable and elderly groups*. *Home Office and Department of Health and Social Care guidance ["will provide" * originally drafted as "provides"] advice for local authorities on dealing with this challenge"* [INQ000047879]

33. The period spanning March – June 2020 has been described by FEMHO as an inflection period during which time policy makers *knew* – or *ought to have known* – of disproportionate death rates among Black, Asian and Minority Ethnic health and social care workers and their wider communities. Given the paucity of data and the absence of a unified, centralised system of data sharing, it is difficult to assess who knew what when. However, in addition to the media coverage outlined in our introduction, there are various NHS Digital Report Slides from March 2020 onwards that paint a clear evidential picture.[1]

34. The March edition does not mention ethnicity but the April edition notes that "*analysis on potential association between ethnicity, comorbidities and outcome*" has been initiated (Slide 2) and "*initiated population health analytics - initial focus on investigating potential association between ethnicity and poorer outcomes"*" (Slide 5). The end of April report includes an ongoing action "*Ethnicity Outcomes Analysis: analysis to investigate high Black, Asian and Minority Ethnic fatalities*" (Slide 3); but there is no mention of ethnicity on the vulnerability slide (though in later editions this is added). Slide 9 of the 30 April report notes: "*rapid investigation completed on potential associations between ethnicity and poor*

[1] See INQ000083059; INQ000083060 ; INQ000083061 ; INQ000083062 ; INQ000083063 ; INQ000083064 ; INQ000083065 ; INQ000083067 ; INQ000083068 ; INQ000083069 ; INQ000083070 ; INQ000083071 ; INQ000083072 ; INQ000083073 ; INQ000083074 ; INQ000083075 ; INQ000083076 ; INQ000083077.

Covid-19 outcomes in Black, Asian and Minority Ethnic individuals in response to multiple requests (inc HDR UK, CMO England). Initial findings shared with CMO and PHE. Joint review being conducted with PHE to compare with findings from separate PHE analysis and agree next steps." Later editions also refer to the risk assessment tool being developed and that this includes ethnicity as a factor. These reports provide an interesting oversight of the development of attention given to ethnicity as a risk factor.

35. In the *Situation Report and Dashboard by Departmental Operations Centre (Home Office) titled Situation Report and Dashboard #150,* dated 22/06/2020 there appears to be no departmental leadership on the state of knowledge on the issue of variability in outcome based on vulnerability and what opportunities exist for mitigation of such risks:

Page 5: SAGE noted the importance of understanding risk to marginalised groups, including migrant workers, and the need to prepare for anticipated outbreaks in areas of high deprivation. The issue will be taken up with Cabinet Office.

Page 25: We are committed to ensuring the safety and wellbeing of our BAME colleagues. The publication of ONS analysis and the PHE report on disproportionate impacts of COVID-19 for the BAME community has caused concern among BAME colleagues. This is a complex subject, and the published reports do not provide solutions or based on best practise and wider sectorial experiences. This is being considered at CS-wide level by CSHR and GPA. We need to understand the evidence as it emerges and will respond at pace. We understand BAME colleagues are anxious and we have provided guidance that they should speak to their line manager about any concerns."

[INQ000053518/5 & 25]

36. There was rigorous analysis that was provided by the *Health Foundation Report July 2020* [INQ000075374]. At p.3, it is noted that: - "*stark differences in COVID-19 outcomes have placed the role of racial discrimination in influencing health outcomes at the centre of debate and will require action to be taken by all sectors of society*"; at p.4 : "*unless these events are viewed through the lens of inequalities we risk ending up in a place of even greater injustice than where we started…There is already much discussion on the theme of 'building back better' to create a more resilient and sustainable economy. This phrase will only ring true if it has the goal of improving health and reducing health inequalities at its heart."* The report further notes at p.11 - "*Data from the ONS published on 7 May show*

that, after adjusting for age, black men and women were at the highest risk and they were more than four times as likely to die from COVID-19 as people of white British ethnicity."

37. Frustration about the responsiveness of policy makers is captured in the *Rule 9 Questionnaire Response from Prof. Vittal Katikireddi (Ethnicity Sub-Group)* [INQ000056486]. Prof Katikireddi is a professor and consultant on public health inequalities and was a member of the SAGE ethnicity subgroup. He was also co-chair of the Scottish Government's Expert Reference group on ethnicity and Covid-19 and we understand was invited to attend SAGE mainly because of his research on ethnic inequalities in Covid-19. Almost every document referenced or listed by Prof Katkireddi relates to health inequalities driven by ethnicity as well as some linking this issue to occupational context. Despite the wealth of insight and suggestion he offered, Prof Katikireddi said it was hardly ever clear whether the advice he was given was being acted upon.

38. Similarly, the witness statement of Professor Kamlesh Khunti (Chair of Scientific Advisory Group for Emergencies Ethnicity sub- group), highlights the limits of expert advice in the policy arena on this issue:

    Page 4: *I have previously opined that* ***universal occupational risk assessments should be provided along with risk reduction strategies to address the disparity of outcomes with regard to ethnic minority workers in healthcare.*** *I did not provide advice on this to SAGE however. I was instead asked directly by NHS England ("NHSE") to chair a group to develop a Risk Reduction Framework [INQ000223041]. This was then conducted entirely through NHSE, with SAGE having no role in implementation; for that reason, I am not certain of the extent to which this was put into place, however, I understand, based on what I have been told by colleagues, that this was implemented in most clinical commissioning groups and hospitals but not all,* ***and implementation has been varied.***

    • Page 6: Point 2.18: *greater efforts could have been made to: implement priority testing for ethnic minority health and social care workers (and their households) across the NHS, implement mandatory occupational risk assessment for NHS and non-NHS staff, with a particular focus on protecting the most vulnerable such as ethnic minority populations.*

    Page 7: A particular area which requires further attention from government to prevent ethnic disparities in future pandemics is to address wider socioeconomic inequalities and deprivation.

Page 11 - Point 2.39: *We also need to have better collection of ethnicity data in routine databases, ensuring data. consistency in complete recording at the higher level ethnicity coding and to train staff appropriately to collect these* data.

[INQ000252609/4; 6; 7 & 11, emphasis added]

II. Failures of pandemic pre-planning

39. In our opening submission for this module, we outlined the key evidence revealed in Module 1 on this topic, and we invite the Inquiry to bear this in mind when considering and drafting the Module 2 report.[2]

40. FEMHO submits that pandemic pre-planning was starkly exposed as catastrophically inadequate and was characterised by successive governments' neglect of matters of inequality and an absence of a planned strategic response to a foreseeable and anticipated pandemic that would inevitably affect different sections of the population in unequal ways. As articulated by Mr Cummings, vulnerable groups were "*almost entirely appallingly neglected by the entire planning system*" [15/142/21-22].

41. The sentiment expressed by Mr Cummings is also eloquently reflected in the expert reflection within a number of Rule 9 questionnaire responses. In the Rule 9 Questionnaire Response from Professor Andrew Hayward, New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG); Environmental Modelling Group (EMG), , he opined: "***A major amount of excess mortality was attributable to ethnic and social inequalities, but little was done to anticipate or address this…***" [INQ000056490/75, emphasis added]. Similarly, in the Rule 9 Questionnaire Response from Professor Iyiola Solanke, Scientific Pandemic Insights Group on Behaviours (SPI-B), dated 14/10/2022 , it was noted that SPI-B had low Black, Asian and Minority Ethnic representation: "*The emergency response was not designed with the realities of poor, BAME, female led households in mind where isolating would be problematic and young men would be trapped in space-deprived homes due to the real expectation of police harassment on the streets.*" [INQ000056545]

42. In addition to the failure of planning to address the foreseeable higher risks for certain population groups, and the inevitable unequal impacts of a pandemic, we submit that basic

[2] Please see paragraphs 6-7 of FEMHO's Written Opening Submissions for Module 2 dated 26 September 2023

resources and capabilities which would need to be drawn on in the event of a pandemic were not accounted for. This includes for example the stockpiles of PPE, discussed in more detail later in these submissions, ready and effective risk assessments and importantly a robust data capture and analysis system.

43. During this module one of the strongest and most unified evidential themes that came from witnesses was as to the appalling state of readiness of the UK's data capture, sharing and analysis capabilities in the early stages of the pandemic. Professor Nazroo, the Inquiry's race inequalities expert, highlighted that the health survey – which he describes as "*perhaps the most important annual monitoring of the health of the population*" [3/33/10-11] and an "*absolutely crucial resource for documenting inequalities in health*" – had not been resourced to include ethnic minority oversamples since 2004 [3/38/24 – 3/39/7]. Another key source he considers "*crucial*", the *Understanding Society Survey* had only "*intermittently*" included questions on racism and discrimination between 2013-2020 [3/62/3-16]. The disengagement with, and lack of investment in, collecting data on ethnic inequalities he opines is a product of institutional racism [3/76/17-22].

44. FEMHO's Ade Adeyemi similarly gave evidence that the Workforce Race Equality Standards – used to measure the progress of ethnic minorities within the NHS – stopped collecting data "*which again creates a kind of culture and understanding that actually they don't really care about this issue*." [4/98/8-10]. Professor Freeguard, the Inquiry's data expert, gave evidence more widely highlighting the government's failure to act on numerous recommendations centred around data improvement in the years leading up to the pandemic. The impact of the poor state of data systems on the response, and in particular the absence of ethnographic data and disaggregation, we submit, cannot be underestimated.

45. In a Report from Department of Health and Social Care, titled *The Government's response to the Health and Social Care Committee and Science and Technology Committee joint report: Coronavirus: lessons learned to date,* dated 17/06/2022 [INQ000075352] it was observed as essential that in any future crisis, NHS staff from Black, Asian and Minority Ethnic backgrounds be included in emergency planning and decision-making structures. NHS England should accelerate efforts to ensure that NHS leadership in every trust, foundation trust and clinical commissioning group is representative of the overall Black, Asian and Minority Ethnic workforce. Leadership in NHS England and Improvement should also increase their engagement with Black, Asian and Minority Ethnic worker organisations and trade unions to ensure that such staff feel valued by the organisation, are involved in

decision-making processes and feel able to speak up when they are not being protected. It was also noted as unacceptable that staff from Black, Asian and Minority Ethnic communities did not have equal levels of access to appropriate and useable personal protective equipment as their White colleagues during the pandemic. The report noted that government must learn from the initial shortage of appropriate PPE for these staff and set out a strategy to secure a supply.

46. We submit that the pre-planning failures to provide for basic inevitabilities are a reflection of the lack of regard given to considerations of inequality. Whilst not excusing failures in decision-making, the lack of provision for inequalities in pre-planning including the underinvestment in data infrastructure was a significant omission which had a direct and substantive impact on the response.

III. Absence of leadership

47. The evidence in this module has unveiled the depth of the "toxic culture" that permeates central government; the infighting and dysfunction that distracted from and hindered the response effort. As elucidated by Mr Cummings, base essentials to effective management and coordination were missing: "*it was extremely difficult to know in Number 10 who exactly in the Cabinet Office was doing what, whose responsibility it was, who were we supposed to talk to, to get action. And that was critical in, particularly in the first couple of months.*" [15/97/23 – 15/98/3] The Inquiry's expert on UK emergency decision-making, Professor Alex Thomas, gave telling evidence on the "*environment amongst the Prime Minister's closest and most senior advisers where they had privately at least entirely lost confidence in his ability to take consistent decisions… the consistency of decision-making was something that could legitimately be criticised and be a cause for concern"* [9/56/19 – 9/58/12]

48. FEMHO submits that there was a profound absence of leadership around the issues that needed to be addressed in order to secure the health and well-being of its members. Boris Johnson's government vacillated, hesitated and prevaricated, implementing lockdown only at the 11th hour in March 2020, when there was an imminent risk of the NHS being overwhelmed. There was a missed and wasted opportunity, with no measures put in place to mitigate the predictably harsher impact that the pandemic would have on Black, Asian and Minority Ethnic health and social care workers and their communities.

49. Importantly, issues related to Black, Asian and Minority Ethnic people were increasingly seen through a political rather than a public health lens, with the ego of one or other leader taking centre-stage. Boris Johnson himself, in a characteristically unserious manner, referred to strategic engagement with ethnic and faith groups around Covid as "*all that jazz*." Far beyond the idiosyncrasies of any one individual leader, this jarring gallows humour was presented over deathly inaction.

50. For example, at a critical period in May 2020, it was clear that Matt Hancock, senior health officials and MPs were aware of Black, Asian and Minority Ethnic staff's claim that they did not have enough PPE and training. Nevertheless, the shambolic state of Department of Health and Social Care (DHSC) leadership took centre stage through the WhatsApp messages of former Minister Matt Hancock from Top Team group, dated 27/05/2020 [INQ000093802]:

Ed Taylor: Told press office to explain that if we don't have a decent line tonight from NHS we are minded to respond to any questions we get in the morning saying we will ask for an NHS investigation into the claims made by RCN about more Black, Asian and Minority Ethnic staff feeling they have lack of PPE and training in use of PPE than white colleagues. Everything he's involved with is just a tedious war of attrition.

Matt Hancock: No problem. If they mess about and it comes up then tomorrow I will hit it very hard. I'm already on the record about racism inside the NHS.

51. Matt Hancock's WhatsApp messages from Top Team group, dated 16/06/2020**.** are similarly illustrative of the misplaced focus on political egos rather than Black, Asian and Minority Ethnic healthcare worker well-being:

Page 2 Natasha Price notes*: "Just had UQ on: To ask the Secretary of State for Health and Social Care what recommendations Public Health England has made regarding* ***increased risks of black Asian Minority Ethnic (BAME) people catching and dying of covid-19; and what action the Government has taken accordingly"****.* Price queries whether this is *"One for Jo C or to push to GEO?"*, the reply From Hancock is "Kemi" (Badenoch). Allan Nixon notes in response: "*There's another debate on BAME deaths re covid that Jo tried unsuccessfully to get Kemi to take. She should make the argument that if Kemi wants to stand at the dispatch box in a couple of months and say what a great job she's done on her review, then she needs to take these debates now..."* To which Ed Taylor responds: "*Kemi has pushed back and supposedly has No10 on her side. I've been pushing to everyone who will listen that Jo C doing this is a terrible idea not only optically,* *but substance wise too. It's a minefield that I don't think she will emerge well from. We have very few options... I also don't understand why we have a GEO if they aren't leading these things."*

Page 9 Emma Dean asks: "*When is the BAME statement in the house - the one we want Kemi to do" to which Ed Taylor responds: "Thursday - Munira now saying has to be Jo C"* [Allan Nixon replies with unidentifiable emoji]

[INQ000093968/2 & 9, emphasis added]

52. Also in June 2020, Matt Hancock's WhatsApp messages with Lord Bethell of Romford, dated 06/06/2020 demonstrate the ruthless manner in which Black, Asian and Minority Ethnic matters simply formed part of everyday political calculations, without more:

Message from James Bethell regarding "Marketing and comms". Second point: "*2. BAME (specifically). I got duffed up again on race in lords. Lots of #BLM stuff from the digital red benches. I did a meeting afterwards with a couple of peers. I guided them away from a broad brush attack and towards a focus on health disparities. But my political danger radar is pinging. it means we really need a upgrade our health inequalities agenda. The stuff from NHS/DH seemed pretty thin. Kemi great, but who's holding this in dept, Jamie? -we are very white? I can nudge but cannot "own"*."

[INQ000163254]

53. We submit that the evidence in this module has revealed a lack of leadership and active engagement amongst decision-makers in response to the disparate impacts on Black, Asian and Minority Ethnic health and social care workers and communities characterised by prevarication, deference and concern as to appearance and political posturing as opposed to urgent attempts to address the issues.

IV. Failings in the contemporaneous strategic response

54. In this section we seek to underscore, through illustrative examples, the myriad ways in which the response fell short for and failed Black, Asian and Minority Ethnic health and social care workers and communities and the devastating impact these failures had on our members.

<u>Failure to act on early Black, Asian and Minority Ethnic healthcare worker infections and deaths</u>

55. As a starting point, FEMHO submits that there was insufficient real time response to the alarming disparities in death rates in Black, Asian, and Minority Ethnic communities. Dominic Raab, deputising for Boris Johnson during the critical time period of relevance, asserted that the phenomenon of disproportionate deaths was not understood within No.10 – or that there was no consensus that reached the threshold for actionable policy making. [28/240/20 – 28/244/3]. Nothing meaningful was done in terms of a strategic response, because of this supposed "*uncertainty*." The absence of any strategic response from government is made even more egregious given there is little or no evidence of any attempt to engage with Black, Asian and Minority Ethnic healthcare leaders during the early, scary days of the pandemic to gain insight and understanding of what they were facing in the absence of usable data.

56. It therefore fell to our members and colleagues to fill the void of government inaction. Some of the first risk assessment tools that were designed to take ethnicity into account, for example, were developed by FEMHO member, BAPIO. More widely, our members were organising and leading a vast array of webinars and online meetings, forums, guidance documents, collective letters and lobbying materials to discuss, raise awareness and educate their communities, wider public and senior officials and decision-makers on the critical issues we were facing.

57. It is worth noting that in an early *paper discussing escalation triggers 24/01/20* at p.1 - one of the triggers the CMO identified for further HMG measures was "*cases in health and social care workers.*" [INQ000047541/1] In a *DHSC/PHE presentation 05/02/20*, a slide notes that the original CMO triggers including that some health and social care workers were being infected were met on 21/01 "*resulting in an increase in the risk assessment*" and raising threat from low to moderate. SAGE agreed next triggers for reassessment would be a severe case in the UK and/or sustained transmission in a country other than China. [INQ000047680]

58. The *Situation Report and Dashboard by Departmental Operations Centre (Home Office) #145, dated 10/06/2020* stated explicitly:

"*There is an increased risk from COVID-19 to BAME groups, which should be urgently investigated through social science research and biomedical research and mitigated by policy makers.*"

[INQ000053446/5]

59. Government witnesses almost unanimously deferred to the commissioning of Kemi Badenoch, Equalities Minister, to investigate the issues. In turn, Ms Badenoch blamed the lack of data for delays in reporting and recommendations. We submit that this work was neither timely nor effective in protecting our members. No witness has been able to satisfactorily explain why mitigation was not more actively considered and acted on in the early stages. We submit that in light of the wealth of evidence that had emerged by mid-April 2020 as to the vastly disproportionate deaths, the case for <u>actively</u> doing something to mitigate and protect the affected groups rather than nothing was overwhelming. This was a failure of catastrophic consequence.

60. Further, the work that was commissioned to examine the disproportionate impact was too subject to criticism and alleged mishandling. The letter from Dr Chaand Nagpaul (BMA Council Chair) to Matt Hancock regarding the removal of recommendations in PHE's report on inequalities and disparities, dated 12/06/2020, is a good example of the type of intervention that was necessary in order to spur strategic responses to the issue of variability of health outcomes based on ethnicity. It pointed out the following:

(p1) serious concern regarding reports that 69 pages covering 7 recommendations for change were removed from the PHE report on inequalities and disparities in the impact of Covid-19 on certain groups. A clear response was needed as to why these pages and important recommendations were omitted from publication, especially when it is so critical that action is taken to save lives now and reduce race inequalities.

(p1) Expression of disappointment that the points raised in BMA submission to the PHE review were not addressed in the report of 2 June. Concern that those pages addressing these and the contributions from other stakeholders may have been removed from the final report.

(p1) The outcome of the review should have been clear recommendations for action to tackle the disturbing reality that the virus is causing disproportionate serious illness and death in BAME *community. This aim was explicit in the review's TOR but the report was completely silent on any recommendations on publication.*

[INQ000097872/1]

61. This caused further concern and mistrust among our members and communities as to the seriousness with which the issue was being taken by government, and the effectiveness of the commission. As will be discussed later in this submission, FEMHO finds it a striking lacuna that the SAGE ethnicity sub-group was not initiated until August 2020. All the while, it was unclear whether and to what extent the valuable submissions, insight and research that individuals and groups took it upon themselves to work on and disseminate to assist decisionmakers were being considered and acted on.

62. The Rule 9 Questionnaire Response from Professor Kamlesh Khunti sums up the central critique about the absence of a contemporaneous strategic response and engagement with advice:

"The recommendations we gave were evidence based, however in some cases there was a lag between when recommendations were made, and the implementation of appropriate strategies - for example, relating to vaccination and vaccine messaging, and increased risk for front-line workers and those living in multigenerational households etc."

[INQ000056560, p.11]

<u>Delays in decision-making</u>

63. Despite the warning signs of the disproportionate impact on ethnic minority groups emerging in mid-March, it was not until August that a SAGE ethnicity sub-group was established. No witness could provide a satisfactory answer as to why this took so long though many referred to the paucity of official data and hesitancy to act without it.

64. The lack of available data, discussed further below, was also a given reason by a number of key witnesses when questioned about the lack of responsive action to disproportionately high deaths and infection rates amongst Black, Asian and Minority Ethnic healthcare workers and communities. Dominic Raab, for example, said "*the data and the evidence was too fluid for us to be able to come to any definitive conclusions, let alone actionable policy making, and therefore we were mindful that there was some clearly more examination of this that was required, and I remember asking -- being involved in those discussions. But we just didn't have enough firm enough conclusions, and the science wasn't firm enough to be able to take it forward.*" [28/240/25 – 28/241/6].

65. Helen McNamara in her witness statement said that the disproportionate impact was treated as a "*naturally occurring phenomena*" and when questioned in oral evidence admitted "*there wasn't enough mindfulness about trying to address inequality as opposed to sort of compounding it without really noticing*" [16/115/5-25]

66. Health Secretary Matt Hancock said he was: "*particularly struck by the death of the first four NHS doctors, three of whom were from an ethnic minority background. I was acutely aware of the disproportionate impact on those from ethnic minority backgrounds, especially amongst the wider NHS workforce as well, not just the doctors and nurses, but also more broadly, including porters and other staff who do vital work and often are very closely in contact with patients. So this is something that I was worried about from early in the pandemic. I'd in fact worked on this before the pandemic, including raising the issues of discrimination within the NHS, and there was -- there was work under way on a particularly difficult issue that came up in NHS BT ^. So there was a wide range of work on this, I was aware of it from the start and I was very glad when Kemi, I was tasked by the Prime Minister to lead and really get to the bottom of this*" [30/23/11 – 30/24/3]

67. Mr Cain acknowledged that the disproportionate effects of Covid-19 on ethnic minorities "*was something that was discussed...but are they given the weight necessary without some of the lived experience? And that's -- I don't know the answer to some of that. It felt to me that sometimes we missed things or didn't give enough attention that we could have done. You know, but I genuinely don't know if, you know, how much that would have impacted*." [15/86/6-14]

68. FEMHO is dismayed at the reliance on the lack of data excuse by key witnesses and decision-makers to account for the delays in responding to the disparate impacts of the pandemic. No witness was able to offer any evidence that any mitigating measures were considered whilst the data was awaited. This is something FEMHO considers inexcusable given the rates of death and infection we faced; had decision-makers genuinely been taking the issue seriously something should have been done in the interim to offer protection and mitigation.

PPE and Risk assessments

69. Module 2 has revealed shocking evidence regarding the decision-making surrounding the supply and procurement of PPE, with more to be revealed in future modules. In these

submissions FEMHO seeks to focus on the specific issues faced by its members in accessing appropriate and fitting PPE.

70. It is now well established that "standard" PPE procured by the UK health sector is designed and manufactured on the facial dimensions of a White Male. This meant that often it did not offer a secure fit for ethnic minority people, particularly women. As Professor Banfield of the BMA raised, and as our members have widely reported, PPE provided to health professionals was often incompatible for people with religious beards and clothing for example turbans and hijabs. Alternative options that would provide a safe and effective fit do exist, for example respirator hoods, however these were by and large not provided for. Again it was left for networks and groups like FEMHO to come up with workarounds to protect themselves in the absence of support and proper equipment from government.

71. Witnesses in Module 2 gave some, albeit caveated, concessions on the overall supply of PPE but the issue of the availability of PPE to fit with cultural and religious dress, or to resolve fit issues arising from the White-Male design, have not been adequately addressed. Lord Simon Stevens admitted that in the early stages of the pandemic the PPE stockpile was insufficient. [17/54/4 – 15/56/9]. In an exchange with FEMHO's senior counsel, Boris Johnson admitted PPE was at times inadequate but he denied knowledge of the fit issues for ethnic minorities alleging that these issues were never escalated to him:

BJ: Right. Well, what we did was to try to make sure that everybody had the best possible protection, and to do whatever we could to stop infection of those particularly black, Asian and ethnic minority ^ groups who were in the frontline of the fight against Covid, and sometimes tragically we didn't have PPE that was good enough but we made a huge effort to equip our country with what was necessary.

LTKC: Sometimes you didn't have PPE, but there was an issue at times, was there not, in relation to PPE not being culturally appropriate, you know, people with beards, religious outfits, things like that? Were you aware of that?

BJ: That wasn't escalated to me. I was concerned that everybody should have the best possible protection.

[32/155/10-24]

72. Concurrently, people from ethnic minorities are less likely to speak up when they had insufficient access to PPE and were found to be less likely to have had an adequate risk assessment despite the high risks they faced. [3/91/25 - 3/92/4] Anecdotal evidence revealed how some were forced to shave their beards to access PPE and/or were only offered ill-fitting PPE and therefore had to work with an increased risk of exposure and face adverse physical and mental health outcomes as a result [4/57/20 – 4/58/3].

73. FEMHO's Ade Adeyemi spoke powerfully on this issue in his oral evidence:

"*most of the PPE that was procured fitted a certain type...so for people of different race, different genders, some with religious you know head scarfs and other ornaments, it was difficult to find the right PPE...when there's noise and disruption of BAME workers its not heard and its not responded to immediately...when we did say these things and when systemically it's happening across the NHS system, across the country, it's not being immediately believed, it's not being immediately responded to, it creates that understanding or perception that there is an institutional systemic response for one set of problems and for our members, black, Asian and ethnic minority workers, there is a different (^inaudible) quick, that's not proportionate to the scale of the problem.*"

[4/106/10 – 4/107/7]

74. He went on to explain how powerless this made individual feel when they were "*not listened to, not believed, not responded to*". He said: "*there is a kind of toxic mess I described here earlier about the power imbalances which mean one most of our members didn't feel able to raise those concerns and the brave ones that did weren't listened to, but it was a palpable thing*" [4/108/5-13]

Lack of engagement

75. Despite the alarmingly disproportionate impacts on Black, Asian and Minority Ethnic health and social care workers that were being flagged to decision-makers and covering the headlines, there was a striking lack of engagement and consultation on the issues.

76. Multiple witnesses commented on how key advisory groups such as SAGE and Independent SAGE lacked diversity [10/83/1-7] & [11/192/3-10]. This left a significant gap in insight into how issues and proposed policies and actions would affect different population groups and be impacted by inequalities [10/184/20 – 10/186/7]. Counsel to the

Inquiry asked Professor Riley, an infectious disease modeller and member of SAGE, whether the lack of diversity "*may have had any actual substantive impact on the way in which scientific advice was provided, bearing in mind of course what turned out to be the disproportionate impact of the pandemic on certain ethnic groups in this country?*" He responded: "*I think it's entirely possible that it did have an impact, yes.*" CTI followed up "*And that would obviously be another reason why that aspect needs to be looked at and corrected as soon as possible?*" Riley responded: "*Yes. It's a common theme across lots of technical disciplines, that historically there has not been sufficient diversity. It would apply to many organisations, certainly beyond SAGE. It's a difficult problem to address but it is an important problem.*" [11/65/14 – 11/66/8].

77. FEMHO members, despite the wealth of insight and assistance we could offer, were not called on and the efforts we made to reach out to key figures and decision-makers often went unanswered. As Ade Adeyemi explained, the lack of engagement and response to attempts to raise critical issues left many "*surprised, upset, a number of other range of emotions that are difficult to describe*". [4/91/25 – 4/92/1]

78. Mr Cain admitted it was "*quite clear that there were challenges of gender diversity, socioeconomic diversity and ethnic minority diversity at the very top*" [15/57/20-22] and "*if you lack that diversity within a team you create problems in decision-making, policy development and culture…I think part of the problem is just very much having a situation where people's own lived experience isn't in the room, so, you know, if you have predominantly middle aged white men you're going to miss out on a whole load of different areas and lived experience.*" [15/71/12 – 15/85/22].

Failings in communications

79. The importance of public trust during the pandemic was a recurring theme in witness evidence and the way in which government communicated with the public highlighted as critical in building and maintaining that trust.

80. Mr O'Donnell described trust as "*absolutely essential*" to the success of the response, particularly given the unprecedented restrictions that were being implemented [6/36/22 – 6/37/1]. It is well known that ethnic minority groups are less likely to have trust in government, in large part due to the structural inequalities they face in their professional and personal lives and collective memories of historical injustices. Former GCSA Mark Walport commented "*it is important to have that communication distributed and reflecting*

the diverse nature of a community." [7/137/7-14] Sir Chris Whitty admitted that exploring ways of improving messaging for ethnic minority groups "*was something we didn't do effectively at the beginning, arguably could have done better throughout*" [24/123/24 – 24/124/1]. Ms Badenoch acknowledged that *"within ethnic minority populations there is a very high level of first-generation immigrants who come from countries where people don't trust the government, and there is no reason to assume that just because the government is saying something, that they will take it as verifiable information that they have to act on".* [25/174/13-19]

81. The Inquiry has heard much evidence about the delays to providing translations of guidance and key information about Covid-19, and how the approach to targeted communication later in the pandemic then further stigmatised certain communities. As Professor Khunti aptly explained: "*if you pick on one minority ethnic group....they will be singled out as a high risk, and that will marginalise them, that will stigmatise the, that will create distrust in that population*". Messages, he said, should be sent to everyone at the same time but in a "*nuanced way*" that ensures it is appropriate for different population groups [7/39/7-15].

82. In the absence of effective communication from government there was little in the way of trust and it fell to FEMHO members as trusted members and leaders within communities to fill the gap and ensure that key messaging was appropriately spread and understood. This required substantial efforts and a dedication of the extremely limited free time they had away from their professional commitments and added considerably to the toll of the pandemic. Chris Whitty commented on FEMHO's work in his evidence stating:

"*Members of, who you represent, did an absolutely astonishingly good job at helping to ensure that did happen. It shouldn't have relied just on them, I fully would acknowledge that (^inaudible) often in their communities or more widely at various points along the pandemic so I think it's important to acknowledge that*"

[24/124/12-19]

<u>*Unavailability of ethnicity inclusive data*</u>

83. In the early critical days and weeks of the pandemic data was scarce, incomplete and disjointed. We heard that as at 21 March 2020 surveillance data was missing over 90% of hospitalisations [1/58/10-19]. Verified case numbers just a couple of days later on 23

March were said at the time to be 6,650 but the true number is now thought to be c.500,000 [1/71/18-22]. Ethnicity data was not being captured and it again fell to FEMHO members and others to collect and disseminate evidence [4/95/24 – 4/96/17].

84. The Inquiry heard from numerous modelling and statistics experts who painted a dismal picture of the state of data in the early stages of the pandemic. Professor Ferguson, when asked about the availability of data sources that included ethnicity told of how they were "*incomplete in many cases, and therefore of difficult -- difficult to use, but most data sources did not provide any information on ethnicity. Neither, therefore, was ethnicity considered in the analysis we were doing at the time."* [11/208/3-7].

85. Professor Medley, Chair of SPI-M-O, confirmed that he was never asked to model outcomes within different population groups; this, he says, was a known issue amongst modellers prior to the Covid-19 pandemic and remains "*a major gap in infectious disease modelling*" [8/113/12-20]. This evidence was echoed by Professor Keeling [8/176/21 – 8/178/22] and Ferguson [11/207/18 – 11/208/21]. Data Scientist Ben Warner when questioned about disparities said: "*I think that our data collection, our analysis, our ability to spend time to look for that, was weak across the board and I think the reason that that is important we strengthen it for the very issues that you're raising now*." [18/182/19-23]

86. Professor Haward reflects that going forwards "*surveillance data really should measure the rates of disease and of hospitalisations and deaths in different subgroups of the population as a matter of routine*" [10/194/19-22] Crucially, he considers that had this been in place from the onset of Covid "*we may have got an earlier signal of that by a few weeks, or possibly more, and that may have drawn attention to those issues and the need to address them earlier."* [10/196/12-15].

87. FEMHO is disappointed at the lack of urgency with which this issue was addressed, particularly given government's apparent ability to quickly set up data processes and systems in other areas.

V. Human rights framework

88. FEMHO submits that the failure to anticipate and respond to disproportionate death rates amongst Black, Asian and Minority Ethnic health and social care workers and communities

constitutes a failure of the government's duty to protect life, enshrined by Article 2 ECHR, and to protect health.

89. The Public Sector Equality Duty, s149 Equality Act 2010, places a positive duty on public authorities to have due regard to the elimination of discrimination and to advance equality of opportunity. There appears in many respects to have been a suspension or dereliction of regard for this statutory obligation. Some Equality Impact Assessments (EIA) and analysis was carried out, however given the paucity of evidence and detail of these we submit suggest that they were more of a "tick box" exercise. For example, in EIAs disclosed to Core Participants various disparate impacts arising from proposals are highlighted however they are almost invariably dismissed and justified by wider public interest in reducing transmission.[3]

90. In a *Report from Health and Social Protection titled form European Social Charter report, dated 02/11/2020* the following was addressed:

"Article 11 - the right to protection of Health" of the European Social Charter and its links to **Articles 2 and 3 of the ECHR:** *"those provisions of international human rights law are closely linked. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".* On the same page (**pg. 1**) it is noted that: "*It is well known that members of certain groups enjoy poorer health and have shorter life expectancy, especially the poor, homeless, jobless or other underprivileged communities and also underprivileged ethnicities".*

Page 2: *"The pandemic did not only place a huge demand on health care services but also revealed in many cases chronic public health underfunding and insufficient capacity to respond to ordinary, let alone extraordinary, needs."*

It is also noted that: *"Access to health care must be* ***ensured to everyone without discrimination.*** *Groups at particularly high risk such as older persons, the homeless or those poorly housed, the poor and destitute, those living in institutions must be* ***adequately protected by the measures put in place.*** *This implies that health equity as defined by the WHO should be the goal: absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. Ideally, everyone should have a fair opportunity to attain their full health potential and no one should be*

[3] See, for example, INQ000059979; INQ000106411; INQ000106414; INQ000110891.

disadvantaged from achieving this potential. ***In the medical fields, there is ample evidence of how women have been victims of prejudice and biased science, to the detriment of their health and wellbeing."***

[INQ000058819/1-2, emphasis added]

91. In the *Draft Agenda item for meeting between EU World Health Assembly and World Health Assembly, regarding EU proposal for a consolidated zero draft on a WHA73: "Covid-19 Response",* dated 15/04/2020, the following suggestion was noted:

    "Adopt a human rights based approach across the whole spectrum of the response to Covid-19, including the duration of states of emergency...paying particularly attention to the needs of the most vulnerable groups, people in vulnerable situations and those in need avoiding stigmatization and discrimination"

    [INQ000050056/5]

Structural racism

92. The Inquiry's expert on race inequalities, Professor Nazroo, gave powerful evidence as to the pre-existing health inequalities for ethnic minorities, including chronic conditions and comorbidities, lower access and satisfaction with primary and secondary healthcare and wider socioeconomic disadvantage. Whilst inequalities should have reduced over time they have persisted; Professor Nazroo's evidence is that structural racism is the underlying cause of the ongoing inequalities. He also notes that interpersonal racism on average appears to have remained consistent over time.

93. Professor Nazroo further emphasised how social and economic inequalities are "*intimately related*" and "*are the driver of higher levels of chronic disease and also a driver of earlier onset of biological ageing. and racism is part of the set of processes that lead to the social and economic inequalities as well as having a direct effect on people's biology*" [3/68/3-9] Professor Khunti, despite arguing that discrimination is difficult to measure, admits "*from the qualitative evidence we have from the British medical association, from the nurses associations, there may have been some elements of structural discrimination*" [7/16/6-9]

94. The reality of how racism played out within our health systems was captured by Ade Adeyemi's evidence. He explained: "*the evidence has been clear for many years... the difference that we see with our white counterparts is stark and it's been existing for many*

years, and so we've had to form these clusters, these networks, to galvanise, share knowledge, to try and address the problem, because so far it hasn't been meaningfully substantively addressed." [4/89/19 – 4/90/5]. Some FEMHO members felt powerless to speak out for fear of negative repercussions for their job and/or visa status. Others who did felt they were disbelieved and ignored. For example, Ade Adeyemi gave evidence that when the issues with oximeters were initially raised they were disbelieved. Evidence has since confirmed that the technology, tested and trialled on white skin, does not work as well on those with darker skin pigmentations. [4/109/20 – 4/110/15] All these and more individual episodes of unfair racial deviation at different levels combine and compound to systemic racism.

Recommendations

95. FEMHO invites the inquiry to make the following recommendations: -

1. **Include ethnicity in Centralised Data Systems:** Government Digital Service (GDS) should require that published datasets from the NHS Digital Strategic Data Collection Service, the Department of Health and Care and its associated Arm's Length Bodies include ethnicity as a critical variable when reporting on workforce, patient, or service user data. This would ensure timely and accurate information to assess and address disparities in health outcomes. FEMHO submits the implementation of real-time monitoring and reporting mechanisms, that includes ethnicity data, especially during public health emergencies, would enable swift responses to emerging disparities and ensure that interventions are implemented promptly.

2. **Diversity and Inclusion in Decision-Making:** The Government Chief Medical Officer (CMO) should ensure diversity and inclusion in the Department of Health and Social Care during public health emergencies. The CMO should convene and chair an advisory group to support government decision makers during emergencies. Depending on the emergency, it may be co-chaired with a relevant expert, with participants varying from meeting to meeting, depending on the expertise required. It is necessary to ensure representation from diverse backgrounds to bring varied perspectives, especially in situations where specific communities are disproportionately affected. Greater community engagement and consultation, particularly with ethnic minority communities, in the development of public health policies and strategies. This would foster trust and ensure that interventions are culturally sensitive and well-received.

3. **Improved Emergency Response Planning:** The Government should develop inclusive emergency response plans that account for pre-existing inequalities, structural racism, and the potential impact on vulnerable populations. This should include specific strategies for protecting healthcare workers and communities from ethnic minority backgrounds.

4. **Mandatory Training on Diversity and Inclusion:** There should be mandatory training, reviewed and revalidated annually, on diversity, inclusion, and cultural competency for senior healthcare professionals and policymakers [VSM and above in NHS England, SCS1 and above in DHSC and its Arm's Length Bodies]. This would contribute to a more equitable response during health crises.

5. **Prioritisation of Vulnerable Groups:** The Government should direct the Health and Safety Executive and MHRA, to encourage the prioritisation of vulnerable groups, including ethnic minorities, in the distribution and use of resources, protective equipment, and access to healthcare services during pandemics.

6. **Research and Analysis on Health Disparities:** FEMHO advocates for increased funding and support for research on health disparities, with a specific focus on understanding the socio-economic and structural factors contributing to disproportionate impacts on ethnic minority communities.

7. **Addressing Discrimination and Bias within the Healthcare System:** It is important that immediate measures are taken to address discrimination and bias within the healthcare system, including policies to ensure fair treatment, equal opportunities, and protection against workplace discrimination for healthcare workers from ethnic minority backgrounds. FEMHO invites the inquiry to recommend the NHS Staff Council makes an amendment to the NHS Terms and Conditions of Service Handbook that internal NHS BAME Staff Networks are formally recognised and valued, like they are in many other public sector organisations.

8. **Integration of Health Inequalities in Public Health Education**: FEMHO proposes the integration of education on health inequalities, structural racism, and cultural competence into public health training programs to better prepare healthcare professionals for addressing diverse and complex health needs.

9. **Ensuring Ethical Data Collection:** FEMHO advocates for the implementation of ethical data collection practices that respect individual privacy rights while still

capturing essential demographic information. This includes clear guidelines on how ethnicity data is collected, stored, and used to prevent any misuse.

10. **Community Health Education Programs:** FEMHO invites the Inquiry to recommend the development and implementation of community health education programs tailored to ethnic minority communities. These programs should focus on raising awareness about preventive measures, access to healthcare, and dispelling misinformation during public health emergencies.

11. **Crisis Communication Strategies:** The Inquiry is invited to recommend that DHSC and NHSE comms teams formulate culturally sensitive crisis communication strategies to disseminate information effectively during public health emergencies. These strategies, in the context of a public health emergency, should mandate intervention and engagement between DHSC, NHSE and UKHSA decision-makers and BAME staff networks and groups within the NHS and collaboration with community leaders and organisations to hear first-hand the issues being faced, soundboard proposed policies and interventions before they are rolled out and ensure accurate and timely information reaches diverse populations.

Conclusion

96. At the outset of the Module 2 hearings Mr Keith KC, Lead Counsel to the Inquiry, made the following observation:

"*If the protection of life is the pre-eminent duty which every government owes to the people, the numbers of those who died is the marker against which the government's response must be judged. This is the stark metric which matters most. Death, my Lady, was the inevitable consequence of a runaway high-consequence infectious disease, and the prevention of death should arguably have been the government's primary obligation…But infection was not inevitable. The figures show a massive difference in mortality rates between the United Kingdom and, for example, South Korea. The overarching question for you in this module will be whether the massive casualties of the first and second waves were the direct result of a plain and obvious failure to put in place proper infection control across the country.*"

[1/6/5-13 & 1/20/2-9]

97. We invite the Chair when considering this critical question to reflect on the particularly stark numbers of Black, Asian and Minority Ethnic health and social care workers who were infected with Covid-19, those now suffering with Long Covid as a result, and those who tragically died. We ask her to keep in the forefront of her mind the evidence heard from multiple witnesses which supports FEMHO's position that the increased risk to this group was entirely foreseeable and yet was completely disregarded in early decision-making. We ask her to address the question of why, when there were such stark early warning signs, there was a lack of urgent and/or effective action to mitigate and protect against the disparate impacts that came to light. We invite her to conclude that the government failed in its duty to protect the lives of Black, Asian and Minority Ethnic health and social care workers. We further invite her to conclude that structural racism played a direct role in why this failure occurred.

98. Successive governments exposed FEMHO's members to increased risk of infection and death from Covid-19 by failing to properly plan for, and respond to, a pandemic of this kind. There was an inexcusable failure to act. This represents a dereliction of government's duty to protect the life and health of Black Asian and Minority Ethnic health care workers – and their communities – during the pandemic.

99. We cannot afford to ignore these realities. We must confront the truth, acknowledge the existence of structural racism, and work collectively to dismantle the barriers that perpetuate inequality. FEMHO commends the Inquiry for undertaking a crucial investigation of the role of structural inequality and structural racism in the pandemic. The time for denial is over and this Inquiry should say so when spelling out what went wrong and why. In recognising the structural and institutional inequalities that plague our society, we acknowledge the undeniable truth that unity arises not from uniformity but from embracing the richness of our diversity.

100. We submit that the evidence is clear: that disproportionalities experienced by Black, Asian and Minority Ethnic people were not only entirely foreseeable, but certainly to an extent preventable. As Jun Pang of Liberty put it, ethnic minorities were "*overpoliced and under protected*" during the pandemic. [21/211/12 – 21/212/12] The devastating loss of life and disparate suffering is a result of government's failure to take proper action to anticipate and mitigate the impact of the pandemic and must not be allowed to be repeated when we face the next public health crisis.

101. We conclude these submissions by returning to the powerful words of Ade Adeyemi on behalf of FEMHO:

“Throughout the course of this pandemic, the disheartening experiences of minority ethnic HCWs have underscored systemic oversights and lapses in our health and governance systems. The poignant accounts of our members, and the stark data supporting them, reflect not just individual tragedies but an overarching narrative of neglect."

[INQ000280065/20-21, para 58]

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